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FOR S/GAC

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SUBJECT: FINDINGS OF THE 2003 DEMOGRAPHIC AND HEALTH SURVEY; MALARIA, CHILD HEALTH, NUTRITION: PART III OF III

REF: (A) LAGOS 1247, (B) LAGOS 1268

¶1. Summary. The findings below were drawn from the executive summary of the 2003 Nigeria Demographic and Health Survey. Malaria remains a major public health problem in Nigeria. Infant mortality is worse than what may have been commonly believed. Most children are under-weight or stunted, especially in northern Nigeria. The rate of vaccination of children in Nigeria is the lowest among African countries in which DHS surveys have been conducted since 1998. The PEPFAR-related program we will pursue in Nigeria calls for complex interagency coordination; we want to begin doing this without delay. We thus seek S/GAC's assistance in identifying a seasoned mid-level officer available now to press forward. End summary.

MALARIA CONTROL

¶2. Nets. Although malaria is a major public health concern in Nigeria, only 12 percent of households reported owning at least one mosquito net at the time of the survey. Even fewer, 2 percent of households, owned an insecticide treated net (ITN). Rural households were almost three times as likely as urban households to own at least one mosquito net. Overall, 6 percent of children below five years of age had slept under a mosquito net including 1 percent of children under an ITN. Five percent of pregnant women had slept under a mosquito net the night before the survey, one-fifth of them under an ITN.

¶3. Use of Anti-malarial Drugs Among Pregnant Women. Overall, 20 percent reported having taken an anti-malarial drug for prevention of malaria during their last pregnancy in the five years preceding the survey. Seventeen percent reported having used an unknown drug, and 4 percent had taken paracetamol or herbs to prevent malaria. Only 1 percent had received intermittent preventative treatment (IPT) or preventive treatment with sulfadoxine-pyrimethamine (Fansidar/SP) during an antenatal care visit. Among pregnant women who had taken an anti-malarial drug, more than half (58 percent) had used Daraprim, which has been found to be ineffective as a chemoprophylaxis during pregnancy. Thirty-nine percent had taken chloroquine, the chemoprophylactic drug of choice until the introduction of IPT in Nigeria in 2001.

¶4. Among children who had been sick and had fever or convulsions, one-third had been given anti-malarial drugs. Most had received the drugs at the onset of the fever/convulsions or the following day.

CHILD HEALTH

¶5. Mortality. On the basis of the 2003 NDHS survey, infant mortality is estimated to be 10 per 1,000 live births for the 1999-2003 period. This rate is significantly higher than the estimates from both the 1990 and 1999 NDHS surveys. The earlier surveys underestimated mortality levels in certain regions of the country, which in turn biased the national estimates downward. The higher rate recorded in 2003 is more likely due to better data than an actual increase in overall mortality risk.

¶6. The rural infant mortality rate (121 per 1,000) was considerably higher in 2003 than the urban rate (81 per 1,000), in large part because of the difference in neonatal mortality rates. As in other countries, low maternal education, the low position of mothers on the household wealth index, and shorter birth intervals are strongly associated with increased mortality risk. The under-five mortality rate for the 1999-2003 period was 201 per 1,000.

¶7. Vaccinations. Only 13 percent of Nigerian children between 12 and 23 months of age could be considered fully vaccinated at the time of the survey; that is, they had received BCG, measles, and three doses each of DPT and polio vaccine (excluding the polio vaccine

given at birth). This is the lowest rate of vaccination among African countries in which DHS surveys have been conducted since 1998. Less than half of the children in the survey had received each of the recommended vaccinations, except polio 1 (67 percent) and polio 2 (52 percent). More than three times as many urban children as rural children were fully vaccinated (25 percent and 7 percent, respectively). WH0 guidelines are that children should be administered all the recommended vaccinations by 12 months of age. In Nigeria, only 11 percent of children between the age of 12-23 months received all the recommended vaccinations before their first birthday.

¶8. Childhood Illness. In the two weeks preceding the survey, 10 percent of the children had experienced symptoms of acute respiratory infection (ARI) and 31 percent had had a fever. Among the children who experienced symptoms of ARI or fever, almost one-third (31 percent) had sought treatment at a health facility or from health care provider.

¶9. About one-fifth of children had had diarrhea in the two weeks preceding the survey. Twenty-two percent of the mothers reported that their children with diarrhea had been taken to a health provider. Overall, 40 percent had received oral rehydration salts (ORS), recommended home fluids, or increased fluids. Less than one-fifth of the children (18 percent) had been given an ORS solution despite 65 percent of the mothers having said they knew about ORS packets. While 20 percent of the mothers said they had given their sick children more liquids than usual, 38 percent of mothers said they had curtailed fluid intake.

NUTRITION

¶10. Breast-feeding. Breast-feeding is almost universal in Nigeria. Ninety-seven percent of children born in the five years preceding the survey had been breast-fed. Just one-third of the children had been given breast milk within one hour of birth (32 percent). Less than two-thirds had been given breast milk within 24 hours of birth (63 percent). Overall, the median duration of any breast-feeding is 18.6 months, but the median duration of exclusive breast-feeding was only half a month.

¶11. Complementary Feeding. Three-quarters of breast-feeding infants between 6-9 months of age-the recommended age for introducing complementary foods-had received solid or semi-solid foods during the day or night preceding the survey. Fifty-six percent had been given food made from grain; 25 percent received meat, fish, shellfish, poultry or eggs; and 24 percent fruits or vegetables. Fruits and vegetables rich in vitamin A had been consumed by 20 percent of the breast-feeding infants 6-9 months of age.

¶12. Nutritional Status of Children. Overall, 38 percent of the children participating in the survey were stunted (short for their age), 9 percent were wasted or thin (low weight-for-height), and 29 percent were under-weight (low weight-for-age). Generally, children living in rural areas or in the north and children of uneducated mothers were significantly more likely to be undernourished than other children. The children in the North West were particularly disadvantaged: one-third were severely stunted, which reflects extensive long-term malnutrition in the region.

ORPHANS

¶13. Less than 1 percent of children nationwide had lost both parents by the time of the survey. Six percent of children under age 15 had lost at least one parent.

COMMENT

¶14. The HIV/AIDS findings in Part I (ref A) of our three-part report on the 2003 Nigeria Demographic and Health Survey provide baseline figures against which we will judge our performance as we implement PEPFAR with our Nigerian hosts. During the next six months, we will set up an in-country interagency mechanism through which to coordinate U.S. and Nigerian HIV/AIDS programs so that the result of our collective effort will be more encouraging than that which would be the case if the interested parties were to work separately. We will need time. Ambassador Tobias, himself, noted in his February 23, 2004 letter introducing PEPFAR to the members on Capitol Hill, that "addressing HIV/AIDS in the developing world requires confronting overstressed and struggling health care systems with limited capacity to provide treatment and care; social inequalities such as those involving the status of

women, girls, and the poor; and the varied economic and political circumstances (as well as diverse and deeply ingrained cultural patterns) as of each country." We will monitor closely and report regularly on the evolution of the indicators reflecting these elements during the next year. We will do so to help channel substantial resources and rapidly expand the delivery of HIV/AIDS services to effective partners committed to the principles of the Emergency Plan.

¶15. Shortly, we will send to HR and AF a position description statement for the person whom we hope will soon arrive at post to focus full time on the PEPFAR and related programs. We would welcome the engagement of the Office of the Global AIDS Coordinator (S/GAC) in an active dialogue with our colleagues in HR to identify a seasoned mid-level officer who is now or will soon be available to fill the position. We would also appreciate being sent a current listing of S/GAC personnel with whom to work on the program components of PEPFAR's implementation in Nigeria.

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